Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WACO ORTH REHAB
PO BOX 2850
BRYAN TEXAS 77805

Respondent Name

AMERICAN MOTORISTS INSURANCE CO

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-04-B816-01

MFDR Date Received

August 19, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied payment for certain medical services…it is our position that these services were reasonable, necessary, and related to the compensable injury."

Amount in Dispute: $219.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue in this case is in regards to Fee Reimbursement. I have attached for your review copies of EOB's showing payment and showing the reason why a payment wasn't made."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 10, 2003 and November 11, 2003	99211-25, 98940, 97124, 98943, 99070, 97024	$219.12	$59.01

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on August 19, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on August 24, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
2. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
3. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment.
4. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 11, 2003
   - N – Not appropriately documented

Issues

1. Did the requestor submit an updated table?
2. Did the insurance carrier pay the requestor for CPT codes 99211-25, 98940, 97124, 99070 rendered on November 10, 2003?
3. Is the requestor entitled to reimbursement for CPT code 98943 rendered on November 10, 2011 and CPT codes 99211-25, 98940, 97024, 98943 rendered on November 11, 2003?
4. Did the requestor submit documentation to support fair and reasonable reimbursement for CPT code 98943?
5. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted an updated table of disputed services on June 3, 2008 removing dates of service that were previously paid by the insurance carrier. The initial disputed amount was $447.22, the new disputed amount is $219.12.
2. Review of the EOB submitted by Broadspire supports that the requestor was paid for CPT codes 99211-25, 98940, 97124, and 99070 rendered on November 10, 2003; therefore the Division will not include the indicated CPT codes in this review.
3. The insurance carrier did not reimburse the requestor for CPT code 98943 rendered on November 10 and CPT codes 99211-25, 98940, 97024 and 98943 rendered on November 11, 2003. The Division will therefore issue a decision on the remaining disputed charges.
4. Per 28 TAC §134.202(b) "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine billing conflicts. Review of the documentation finds:
   - CCI Edit – CPT code 98940 and component procedure CPT code 99211 is unbundled. The Standard Policy Statement reads "CPT Manual and CMS coding manual instructions". The use of an appropriate modifier may be allowed. This E/M service, Procedure 99211, should not be billed on the same date of service as CPT code 98940 without modifier -25. The requestor appended modifier -25 to CPT code 99211. No edit conflicts were found.
5. Per 28 TAC §134.202(c) "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications. (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%..." The requestor is entitled to reimbursement for the following:
   - CPT code 99211, MAR amount is $23.35. The requestor is entitled to $23.35.
   - CPT code 98940, MAR amount is $30.13. The requestor is entitled to$30.13.
   - CPT code 97024, MAR amount is $5.53. The requestor is entitled to $5.53.
6. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor Code §413.011(d)], until such period that specific fee guidelines are established by the commission."
7. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

8. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that

discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that.

- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for CPT code 98943.
- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

9. The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended for CPT code 98943.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $59.01.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $59.01 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 22, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.